WELCOME

We are pleased to welcome you to our practice. We believe in treating patient like family with honest compassionate care. Thank you for choosing Ocotillo Lakes Endodontics.

Date _____

PATIENT INFORMATION

Name _____ Soc. Sec. #_____

Address _____

City _____State _____ Zip _____

Phone # (H) _____ (W) _____ (C) _____

Birthdate _____ Occupation _____

Person to contact in Case of Emergency _____

Relationship to you _____ Phone # (H) _____ (C) _____

Whom May We Thank for Referring You? _____

PRIMARY DENTAL INSURANCE

Insurance Company _____ Group#_____

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security# _____ Phone # (H)_____

Address _____

City _____State _____ Zip_____

Employer _____ Business Phone #_____

Business Address _____ City_____State _____ Zip_____

SECONDARY DENTAL INSURANCE

Insurance Company _____ Group # _____

Subscriber Name _____ Relationship to Patient _____

Birthdate _____ Social Security# _____ Phone # (H) _____

Address (if other than Patient) _____

City _____ State _____ Zip _____

Subscriber Employed By _____ Business Phone# _____

(over)

Patient Name:

Health Information

Reason for today's visit _____

Dentist Name _____ Phone #_____

Check if you have had problems with any of the following:
____Have you had a history of a heart attack or stroke?
____Are you required to take antibiotics before every dental visit?
____Do you have any orthopedic hardware other than pins/screws?
____Are you currently or have you previously taken biosphosphonates?

Health History

Physician's Name _____ Phone # _____

Are you currently under a physician's care? ____ Yes ____ No

If yes, please describe: _____

Are you required to take an antibiotic before dental procedures? ____ Yes ____ No

Women: Are you pregnant? ____ Yes ____ No *Nursing? ____ Yes ____ No* *Taking Birth Control? ____ Yes ____ No*

Place a mark on "Yes" or "No" to indicate if you had any of the following:

AIDS	Yes____ No____	Epilepsy	Yes____ No____	Psychiatric Care	Yes____ No____
Anemia	Yes____ No____	Fainting or Dizziness	Yes____ No____	Radiation Treatment	Yes____ No____
Arthritis, Rheumatism	Yes____ No____	Glaucoma	Yes____ No____	Respiratory Disease	Yes____ No____
Artificial Heart Valves	Yes____ No____	Heart Murmur	Yes____ No____	Rheumatic Fever	Yes____ No____
Artificial Joints	Yes____ No____	Heart Problems	Yes____ No____	Scarlet Fever	Yes____ No____
Asthma	Yes____ No____	Hepatitis	Yes____ No____	Shortness of Breath	Yes____ No____
Back Problems	Yes____ No____	Herpes	Yes____ No____	Sinus Trouble	Yes____ No____
Bleeding Disorder	Yes____ No____	High Blood Pressure	Yes____ No____	Skin Rash	Yes____ No____
Cancer	Yes____ No____	HIV Positive	Yes____ No____	Special Diet	Yes____ No____
Chemical Dependency	Yes____ No____	Jaundice	Yes____ No____	Stroke	Yes____ No____
Chemotherapy	Yes____ No____	Jaw Pain	Yes____ No____	Swelling of Feet/Ankles	Yes____ No____
Circulatory Problems	Yes____ No____	Kidney Disease	Yes____ No____	Swollen Neck Glands	Yes____ No____
Congenital Heart Lesion	Yes____ No____	Liver Disease	Yes____ No____	Thyroid Problems	Yes____ No____
Cortisone	Yes____ No____	Low Blood Pressure	Yes____ No____	Tonsillitis	Yes____ No____
Diabetes	Yes____ No____	Mitral Valve Prolapse	Yes____ No____	Tuberculosis	Yes____ No____
Emphysema	Yes____ No____	Neurological Disorder	Yes____ No____	Ulcer	Yes____ No____

Medications

List Medications you are taking:

_____
_____
_____
_____
_____

Allergies

_____ Aspirin
_____Clindamycin
_____ Codeine
_____ Iodine
_____ Latex
_____ Local Anesthetic
_____ Penicillin
_____ Sulfa
_____ Other _____
_____

Authorization

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. If there are any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without failure.

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for the services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I will be charged for appointments cancelled or broken without 24 hours advance notice.

Signature _____ Date _____

Financial Agreement

We hope this information will answer your questions about our office's financial and insurance policies.

Payment is expected at the time service is performed. We make every effort to keep down the cost of your endodontic care. You can help by paying upon completion of each visit. Estimated Payment: As a courtesy, we may contact your insurance company and based on the information they provide, calculate an estimated portion. This is only an estimate and may change based on what your insurance company actually pays.

Patient payments: Payments is due at the time of service. We accept cash, credit card, CareCredit.

Patients with Dental Insurance: Your insurance plan is a contract between you, your employer and the insurance company. For your convenience we will accept direct payment from your insurance company when you pay the estimated co-payment at the time of treatment (Prompt reimbursement will be made for any overpayment.) Some companies pay fixed allowances for certain procedures and other pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorneys' fees, and court costs. Our treatment is rendered to you; therefore you are the responsible party.

Consultations: Because insurance company policies vary for coverage of specialist consultation, the full fee for a consultation may be due at time of service regardless of insurance coverage.

Collections: Most of our patients are very conscientious about their accounts, but occasionally we have difficulty with collections. If an account is delinquent and cannot be cleared within 60 days, it will be reported to a collection agency. We prefer not to use a collection agency, but if circumstances make it necessary an additional 33% will be added to your balance by the collection agency as a fee for their services.

Our entire staff is committed to providing you with the best possible endodontic care. If you have any questions, please do not hesitate to ask.

Signature _____ Date _____

Examination Authorization

I authorize my endodontist and any designated staff to perform an endodontic examination for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of x-rays and CBCT images and intraoral photography required as necessary part of this examination and treatment. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

Signature _____ Date _____

Consent For Use And Disclosure of Health Information

Purpose of consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

Notice of Privacy Practices: By signing this form, you acknowledge that you received a copy of our Notice of Privacy Practices. Our Notice of Privacy Practices provides a description of our treatment, payment activities, health care operations, and other uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read the Notice of Privacy Practices carefully and completely before signing this Consent.

I have received a copy of, and full opportunity to read your Notice of Privacy Practices and this Consent form. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment payment activities and health care operations.

Signature _____ Date _____